APPENDIX S
FINANCIAL REPORTING GUIDE FORMS

ORGANIZATION STRUCTURE AND FINANCIAL PLANNING FORM

1) If other than a government agency:

   a) When was your organization formed?

   _____

   b) If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.

2) License/Certification

   a) Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:

SERVICE COMPONENT	LICENSE /REQUIREMENT	RENEWAL DATE

   b) Have any licenses been denied, revoked or suspended?

   Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

   Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

   Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

   Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the offeror's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons?

   (note: Check with Local Zoning ordinances for handicapped requirements.)

   Yes _____ No _____

   If yes, briefly describe how such assurance is provided.

If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, Plan Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

6) Federal Government Suspension/Exclusion

Has offeror been suspended or excluded from any federal government programs for any reason?

Yes _____ No _____ If yes, please explain:

FINANCIAL PLANNING FORM

1) Is the offeror's accounting system based on a cash, accrual or modified method?

   (a) Cash [ ]
   (b) Accrual [ ]
   (c) Modified [ ] give brief explanation

2) Does the offeror prepare an annual financial statement?

   Yes _____ No _____ If yes, provide a copy of the latest report.

3) Are interim financial statements prepared? Yes _____ No _____

   a) If yes, how often are they prepared? _____

   b) If yes, are footnotes and supplementary schedules an integral part of the statements? Yes _____ No _____

   c) If yes, are actuals analyzed and compared to budgeted amounts? Yes _____ No _____

   d) If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

4) Is the offeror audited by an independent accounting firm/accountant?

   Yes _____ No _____

   a) If yes, how often are audits conducted? _____

   b) By whom are they conducted? _____

   c) Did this auditor perform the offeror's last audit?

      Yes _____ No _____

      If no, provide the name, address and telephone number of the firm that performed the offeror's last audit.

d) Are management letters on internal controls issued by the accounting firm?

Yes _____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the offeror, by its submission, certifies the letter is unaltered.

If no, the offeror shall provide a comprehensive description of internal control systems. The offeror is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

e) Do you have any uncorrected audit exceptions?Yes _____ No _____

If yes, provide a copy of the auditor's management letter (see 4 [d] of this form for instructions regarding submittal).

5) Does the offeror have an accounting manual? Yes _____ No _____

If no, the offeror must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The offeror agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the offeror have a formal basis to allocate indirect costs reflected in your financial statement? Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

7) What types of liability insurance does the offeror have?

(a) With what Company(s)?_____

(b) What is the amount of coverage for each type of insurance?
$_____

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the offeror or its owner(s).

9) Are there any suits, judgments, tax deficiencies, or claims pending against the offeror? Yes _____ No _____

Briefly describe each item and indicate probable amount.

$_____

10) Has the offeror or its owner(s) ever gone through bankruptcy?

Yes _____ No _____

When?_____

11) Do(es) the offeror's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?
Yes _____ No _____

If yes, describe the dollar amount(s) and source(s) of all funding.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

12) Does the offeror have a performance bonding mechanism in accordance with DHS Rules? Yes _____ No _____

If yes,

Amount of Bond: $_____
Term of Bond: _____ Term of Bond: _____
Bonding Company: _____
_____
Restrictions on Bond: _____
_____

If no, describe how the offeror intends to provide a bond and/or security to meet established DHS Rules.

13) Does the offeror have a financial management system to account for incurred, but not reported liabilities? Yes _____ No _____

If no, the offeror must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's. The offeror, regardless of response (either yes or no) must complete items "a" through "h" below.

a) Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____

b) How often are IBNR's projected? _____

c) Identify all major data sources most often used.

d) Are data from open referrals and prior notifications used?

Yes _____ No _____ If so, how?

e) Are detailed written procedures maintained? Yes _____ No _____

f) Are IBNR amounts compared with actuals and adjusted when necessary?

Yes _____ No _____

g) Is the basis of periodic IBNR estimates well documented?

Yes _____ No _____

h) The offeror must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the offeror is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the offeror will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

14) Does the offeror have a full-time (100%) controller or chief financial officer?

Yes _____ No _____ If yes, Enter Name: _____

15) Are the following items reported on the offeror's financial statements?

a) Medicare Reimbursement Yes _____ No _____
b) Other third-party recoveries Yes _____ No _____

If no, explain why.

16) Was an actuarial firm used to assist in developing capitation rates?

Yes _____ No _____ If yes, what is the name of actuary and actuarial firm.

_____, _____
Actuary Actuarial Firm

17) Did a firm or organization provide the offeror with any assistance in making this offer (to include developing capitation rates or providing any other technical assistance)?

Yes _____ No _____

If yes, what is the name of this firm?

_____
Name

_____
Address

FINANCIAL PERFORMANCE FORM

The offeror must indicate its current status for each measure (based on their most recent audited financial statements below).

FINANCIAL MEASURES	OFFERORS CURRENT STATUS* (Audited)	(Unaudited)	TARGET VIABILITY CRITERIA
Working Capital Ratio	_____	_____	At Least .90
Equity per Enrollee	_____	_____	At Least $100.
Net Medical Costs as a % of Capitation Revenues	_____	_____	No More Than 88% (plans over 8,000 members) No More Than 86% (small plans of 8,000 members and under)
Administrative Costs (To include Contingencies) as a % of Capitation Revenues	_____	_____	No More Than 8% (plans over 8,000 members) No More Than 8% (small plans of 8,000 members and under)
Day Claims Outstanding	_____	_____	No More Than 90 days (IBNRs)
	_____	_____	No More Than 45 Days (RBUCS)

*Audited Current Status means measures developed from offeror audited financial statements for the most recently completed fiscal year. Unaudited Current Status means measures developed from the most recent year-to-date offeror internally prepared financial statements. All changes of more than 2% for working capital, $10 for equity per enrollee, 3% for net medical cost, 2% for administrative cost, or 10 days for claims outstanding must be explained in written narrative and submitted as part of the offeror's response to this request for proposal.

A new offeror is to project these ratios based on its financial plan. Insert the projected ratios in the "Unaudited" column.

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the offeror fails to disclose ownership or controlling information and related party transaction as required by this policy.

Financial Disclosure requirements in accordance with 42 CFR 455.100 through 455.106 are:

455.104 Information on Ownership & Control

(1) The name and address of each person with an ownership or controlling interest in the disclosing entity.

(2) The name and address of each person with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

(3) Names of persons named in (a) and (b) above who are related to another as spouse, parent, child or sibling of those individuals or organizations with an ownership or controlling interest.

(4) The names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

(5) The ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the past 12-month period.

(6) Any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the past five-year period.

455.106 Information on Persons Convicted of Crimes

(7) Name of any person who has an ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror, and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

b) Additional information which must be disclosed to DHS is as follows:

(1) Names and addresses of the Board of Directors of the disclosing entity.

(2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

(3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

(1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

(2) Describe <u>all</u> transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires <u>advance</u> administrative review by the Director before being made.

(3) As used in this section, "related party" means one that has the power to control or significantly influence the offeror, or one that is controlled or significantly influenced by the offeror. "Related parties" include, but are not limited to, agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers,

parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

42 CFR 455.101 DEFINITIONS

a) "Agent" means any person who has been delegated the authority to obligate or act on behalf of a provider.

b) "Convicted" means that a judgment of conviction has been entered by a Federal, State or local court, regardless of whether an appeal from that judgment is pending.

c) "Disclosing entity" means a QUEST provider or health plan.

d) "Other disclosing entity" means any other QUEST disclosing entity and any entity that does not participate in QUEST but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVIII, or XX of the Social Security Act. This includes:

(1) Any hospital, skilled nursing facility, home health agency,. independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII);

(2) Any Medicare intermediary or carrier; and

(3) Any entity that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XIX of the Social Security Act.

e) "Fiscal agent" means a contractor that processes or pays vendor claims on behalf of DHS.

f) "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

g) "Indirect ownership interest" means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

h) "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or

managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

i) "Ownership interest" means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

j) "Person with an ownership or controlling interest" means a person or corporation that:

(1) Has an ownership interest totaling five (5) percent or more in a disclosing entity;

(2) Has an indirect ownership interest equal to five (5) percent or more in a disclosing entity;

(3) Has a combination of direct and indirect ownership interests equal to five (5) percent or more in a disclosing entity;

(4) Owns an interest of five (5) percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five (5) percent of the value of the property or assets of the disclosing entity;

(5) Is an officer or director of a disclosing entity that is organized as a corporation; or

(6) Is a partner in a disclosing entity that is organized as a partnership.

k) "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and five (5) percent of an offeror's total operating expenses.

l) "Subcontractor" means:

(1) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

(2) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the DHS agreement.

m) "Supplier" means an individual, agency, or organization from which a Provider purchases goods and services used in carrying out its responsibilities under its DHS contract (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

n) "Wholly owned subsidiary supplier" means a subsidiary or supplier whose total ownership interest is held by an offeror or by a person, persons, or other entity with an ownership or controlling interest in an offeror.

DISCLOSURE STATEMENT

PLAN NAME/NO. _____
DISCLOSURE STATEMENT FOR THE YEAR ENDED_____

I hereby attest that the information contained in the Disclosure Statement is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Health Plan, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in QUEST.

_____ _____
Date Signed Chief Executive Officer
(Name and Title Typewritten)

Notarized _____ _____
Signature

DISCLOSURE STATEMENT
OWNERSHIP

Health Plan Name, Plan No.:_____
Address (City, State, Zip):_____
Telephone: _____

For the period beginning: _____ and ending _____

Type of Health Plan:

- o Staff – A health plan that delivers services through a group practice established to provide health services to health plan members; doctors are salaried.
- o Group – A health plan that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- o IPA – A health plan that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- o Network – A health plan that contracts with two or more group practices to provide health services.

Type of Entity:

- o Sole Proprietorship
- o Partnership
- o Corporation
- o Governmental
- o For-Profit
- o Not-For-Profit
- o Other (Specify) _____

455.104 Information on Ownership and Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership interest" means the possession of equity in the capital, the stock, or the profits of disclosing entity, directly or indirectly.

Name	Address	Percent of Ownership of Control

b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more.

Name	Address	Percent of Ownership of Control

c. Names of persons named in (a) and (b) above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

455.105 Information Related to Business Transactions

e. List the ownership of any subcontractor with whom the offeror has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

f. List any significant business transactions between the offeror and any wholly owned supplier or between the offeror and any subcontractor during the five-year period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

455.106 Information on Persons Convicted of Crime

g. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Address	Title

2. Additional information which must be disclosed to DHS as follows:

a. List the names and addresses of the Board of Director of the Plan.

Name/Title	Address

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title	Address

c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

Name	Address	Amount of Debt	Description of Security

DISCLOSURE STATEMENT

a. Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the offeror's ability to meet QUEST objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected in the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the offeror. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the offeror and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact on the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

b) The furnishing for consideration of goods, services or facilities:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

2. Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

CONTROLLING INTEREST FORM

The offeror must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., about to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the offeror's proposal as unresponsive.

NAME	ADDRESS	OWNER OR CONTROLLER	HAS CONTROLLING INTEREST	
			YES	NO

BACKGROUND CHECK INFORMATION

The offeror must provide sufficient information concerning key personnel (i.e., Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

NAME**	EVER KNOWN BY ANOTHER NAME* YES	NO	SOCIAL SECURITY ACCOUNT NUMBER	DATE OF BIRTH (DA/MO/YR)	PLACE OF BIRTH CITY/COUNTRY /STATE

* If yes, provide all other names. Use a separate sheet if necessary.
**For each person listed:

a) give addresses for the last 10 years
b) ever suspended from any federal program for any reason?

Yes o No o If yes, please explain.

OPERATIONAL CERTIFICATION SUBMISSION

The offeror must complete the attached certification as documentation that it shall maintain member handbook, appointment procedures, referral procedures and other operating requirements in accordance with either DHS rule(s) or policies and procedures.

By signing below the offeror certifies that it shall at all times during the term of this contract provide and maintain member handbook, appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The offeror warrants that in the event DHS discovers, through an operational review, that the offeror has failed to maintain these operating procedures, the offeror will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

_____ _____

Signature Date

GRIEVANCE SYSTEM FORM

The offeror must complete the form below and submit with this proposal.

I hereby certify that _____
(Offeror Name)
will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and assure the participation of individuals with authority to require corrective action.

I further understand the offeror must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the offeror. The grievance policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance procedure shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

_____ _____
Authorized Signature Date

_____ _____
Printed Name Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposals for medical services. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned offeror and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications. We also affirm, by signing this proposal, that we have reviewed the reference materials in the State's documentation library and that we have used this documentation as a basis for submitting our firm fixed price cost proposal.

It also understood that failure to enter into the contract upon award shall result in forfeiture of the surety bond. We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications.

_____ _____

Authorized Offeror's Signature/Corporate Seal Date

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence on officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.

3. This certification is a material representation of fact upon which reliance was placed when this trancsction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for such failure.

Offeror: _____

Signature: _____

Title: _____

Date: _____

APPENDIX T
RISK SHARE PROGRAM

Objective of the Program: The State acknowledges that due to circumstances beyond the control of the health plans and the State, the established capitation rates may not be appropriate for the services to be provided. Even with utilization data and experience with the current QUEST, QUEST-Net and ABD programs, it is difficult for the plans and the State to accurately predict the actual performance or utilization of services by the enrolled population. It is possible that more recipients will utilize more services than estimated. Conversely, it is also possible that more recipients will utilize substantially less services than estimated.

To address the unknown risk to the health plans and the State, DHS will implement a risk share program. The risk share program will be applied when there is an overall impact on the program such that there is a significant differential between the total funds provided to the plans for health care and the aggregate health care expenses of the plans. It is not intended to protect any one plan from poor performance due to ineffective management of utilization, or the inability to negotiate effective and economical contracts. The risk share program cannot be activated by a single plan.

Conceptual Framework: Under the risk share program, DHS will share in a significant difference between the capitated revenues and the actual costs experienced by the totality of the plans. Six months following the end of the fiscal year (by December 31), using the financial reports provided by the participating plans, a simple profit and loss statement will be developed for the health services portion of the QUEST and QUEST-Net programs. Administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the health services to the enrolled population.

Following the computation of the aggregate profit and loss statement, a net loss or gain percentage will be computed based upon the total capitations paid to the plans for health care. If the loss percentage is within a 5% risk corridor, there will be no loss sharing between DHS and the plans and the plans will absorb all of the loss. If the aggregate loss is outside of this risk corridor, DHS will share equally in the loss exceeding the risk corridor up to the risk share limit of $5,000,000. If there is an aggregate gain exceeding 3%, DHS will share equally in the gain between 3.1% and 4.9%. DHS will recover all gains equal to and exceeding 5%.

If there is to be risk sharing, each plan would be compensated individually based on the number of eligible months. Using an example of a net loss of 7%, with the risk corridor at 5%, the 2% difference would be shared equally between DHS and the plans up to $5,000,000. Since DHS and the plans share equally in the loss, the amount to be remitted back to the plans is 1% of the total capitations paid to the plans for health care. Only plans experiencing an actual loss will benefit from the risk share program.

Similarly, if there is a net gain of 7%, there will be profit sharing for the 4% difference beyond the 3% corridor. The first 2% difference will be shared equally between DHS and the plans. The second 2% will be returned to the State. Only plans experiencing an actual gain above the 3% corridor will be required to reimburse the State.

The individual amounts to be remitted to the plans or to the State will be distributed based on eligible months. The following formula will be used to determine the aggregate gain/loss*:

∑Total revenue (based on capitations paid to each plan for the health care portion)

Less: Net health care expenses (based on the actual experience for health care)

Net profit/loss (for the health care services provided to QUEST and QUEST-Net populations)

The net profit/loss divided by the total revenue will provide a percentage of the profit/loss which will be compared to the risk corridor established by DHS.

* The following definitions apply:

Capitations paid to each plan are computed as follows: (Based on the negotiated rate, the services portion of the capitation rate ÷ total capitation rate) x number of eligible months. Each of the plans' capitations are summed together to determine the total revenues to the plans.

Net services expenses will be based on the actual service expenses less any reimbursements from third party reimbursements. The expenses will be taken from the financial reports provided by the health plans for the year ended June 30. DHS recognizes that the financial reports are due within 45 days from the end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the profit/loss statement for the risk share program, the plans will be requested to update their prior year's report for any adjustments. The report will be due to DHS by January 15.

All net expenses for all plans will be summed to determine the total net expenses for care.

Examples: The following examples illustrate how the Risk Share Program would be applied in aggregate and individually to the plans

Example 1: Aggregate Program Calculation for Loss

Plan	Recipient Months	Capitation Paid (total)	Services Portion %	Services Portion $	Total Expenses	Net Profit (Loss)
A	345,000	20,700,000	90%	18,630,000	22,500,000	-3,870,000
B	100,000	6,000,000	92%	5,520,000	7,500,000	-1,980,000
C	92,000	5,520,000	95%	5,244,000	7,500,000	-2,256,000
D	700,000	42,000,000	90%	37,800,000	35,000,000	2,800,000
	1,237,000	74,220,000		67,194,000	72,500,000	-5,306,000

Total Capitations Paid to the Plans for Care	67,194,000	
Total Expenses Related to Care	72,500,000	
Net Loss	5,306,000	
Loss Percentage for the Program	7.90%	
Risk corridor is 5%	-5.00%	
% of loss to be shared equally between plans and DHS		2.90%
% to be returned to plans (50/50 share)	1.45%	

Since in aggregate, the program experienced a loss greater than the 5% corridor, the risk share program will be implemented.

Example 2: Distribution to the Plans

The plans and DHS share equally in the loss over 5% (i.e., in this example 2.9%). The total amount to be returned to the plans is calculated based on 1.45% of the services portion of the capitations received by the three plans experiencing a loss (1.45% x $29,394,000). A per capita amount to be returned can be calculated using the total amount to be returned divided by the total number of recipient months served by the three plans ($426,213 ÷ 537,000). In this example, the per capita amount would be $0.79 per recipient month. As long as the $5,000,000 limit was not reached, the calculation would be computed as follows: Each plan will receive $0.79 per recipient month. Plan A would receive $272,550 (345,000 x .79); Plan B would receive $79,000 (100,000 x .79); and Plan C would receive $72,680 (92,000 x .79). Plan D would not receive any payment from the Risk Share Program since it did not actually experience a loss.

If the limit of $5 million had been exceeded, each plan will receive a pro rata share of the $5,000,000 based on the plan's recipient months. Plan A would receive $3.2 million (64% x 5,000,000); Plan B would receive 950,000 (19% x 5,000,000) and Plan C would receive 850,000 (17% x 5,000,000).

Example 3:Aggregate Calculation of Gain

If there is a net gain, the net gain percentage will be computed and distributed among the plans exceeding the 3% allowable gain.

Plan	Recipient Months	Capitation Paid (total)	Medical Portion %	Medical Portion $	Total Expenses	Net Profit (Loss)
A	345,000	20,700,000	90%	18,630,000	15,500,000	3,130,000
B	100,000	6,000,000	92%	5,520,000	5,500,000	20,000
C	92,000	5,520,000	95%	5,244,000	7,500,000	-2,256,000
D	700,000	42,000,000	90%	37,800,000	35,000,000	2,800,000
	1,237,000	74,220,000		67,194,000	63,500,000	3,694,000

Total Capitations Paid to the Plans for Care	67,194,000
Total Expenses Related to Care	63,500,000
Net Gain	3,694,000
Gain Percentage for the Program	5.50%
Risk corridor is 3%	-3.00%
% of gain to be share between plans and DHS	1.50%

Since in aggregate, the program experienced a gain greater than the 3% corridor, the risk share program will be implemented.

Example 4: Distribution to the Plans

The plans and DHS share equally in the gain between 3% and 5% and any gain at or over 5% is returned to the State. If a plan has a gain over 5%, the maximum amount that the plan will be allowed to retain will be 4%. The gain allocation would be applied only to plans which experienced a gain over 3%. In this example, since Plan C experienced a loss, it would not return any money to the State. Plan B would also not return any money to the State because its gain was less than 3%. Since Plan A had a gain of 16.8% and Plan D a gain of 7.4%, each would be allowed to retain 4%. In this

example, Plan A would retain $745,200 and return to DHS $2,384,800. Plan D would retain $1,512,000 and would return $1,288,000.

APPENDIX U
TPL MEDICAL/DENTAL EXPENSE REPORT

The report shall include the following data:

1. DHS Recipient I.D. No.
2. Patient Name
3. Birthdate
4. Provider No.
5. Provider Name
6. Referring/Prescribing Physician No.
7. Service dates (from -to)
8. Paydate
9. Claim control no.
10. Reject code
11. N- paydate
12. Payee no.
13. Accident Date
14. Diagnosis code/description 1,2, 3, 4, 5
15. Procedure/MOD/NDC
16. SVC/REV Description
17. SVC - Dt
18. S/Qty
19. Charge
20. Allowance
21. Claim Total
22. Patient's share
23. Other insurance payment
24. Refund code
25. Payment Period
26. Page No.
27. Adjustments

APPENDIX V
PROVIDER NETWORK MATRIX

Island: _____

Provider Type: Primary Care Providers*

	Name (last name, first name, M.I.)	Specialty	Location (Address) (list all that apply separately)	City	Zip Code	No. of Current QUEST Plan Members	Accepting New QUEST Members? Y/N	Any Limit on QUEST Members ?Y/N
1.								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								

* PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYNs, clinics. Nurse midwives, pediatric nurse practitioners, family nurse practitioners should be listed separately.
Sort PCPs by different provider types and list alphabetically within the different provider type by last name.
PCPs should be placed on island map.

	Name (last name, first name, M.I.)	Specialty	Location (Address) (list all that apply separately)	City	Zip Code	No. of Current QUEST Plan Members	Accepting New QUEST Members? Y/N	Any Limit on QUEST Members? Y/N
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36								
37								
38								
39								
40								
41								
42								
43								
44								
45								
46								

* PCPs include pediatricians, family practitioners, general practitioners, internists, OB/GYNs, clinics. Nurse midwives, pediatric nurse practitioners, family nurse practitioners should be listed separately.
Sort PCPs by different provider types and list alphabetically within the different provider type by last name.
PCPs should be placed on island map.

APPENDIX W
MONTHLY CAPITATED RATE

The monthly capitated rate(s) for a **QUEST** recipient is (are):

	Oahu	Hawaii	Maui	Molokai	Lanai	Kauai
Medical	$_____	$_____	$_____	$_____	$_____	$_____
Administrative Costs [1]	$_____	$_____	$_____	$_____	$_____	$_____
Profit	$_____	$_____	$_____	$_____	$_____	$_____
Total	$_____	$_____	$_____	$_____	$_____	$_____

[1] Administrative costs limited to 10% of the capitated rate. This amount should agree to the detail of major components on Administrative Costs Assumptions.

The above amounts should be based on the enrollment assumptions provided.
The above amounts are before any general excise taxes.

APPENDIX W
ACTUARIAL COST AND UTILIZATION ASSUMPTIONS
QUEST

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Service	**Unit of Service**	**Annual Utilization Per 1,000 Eligibles**	**Cost Per Unit**	**Explanation of Assumptions [1]**	**Increase (Decrease) in Utilization**	**Increase (Decrease) in Cost per Unit**	**Cost Per Member Per Month**
Inpatient Hospital Total	Days						
Hospital (Surgery, ICU/CCU, Medical)	Days						
Maternity	Days						
Psychiatric	Days						
Nursing Facility	Days						
Outpatient Hospital Total	Visits						
Emergency Room	Visits						
Other Facility	Visits						
Other Ancillary	Visits						

[1] List/describe the assumptions used to derive the utilization and costs estimates. For example, if utilization was derived from DHS claims data and decreased due to the implementation of managed care, such explanation would be placed in Column 5. The percentage increase or decrease in utilization would be placed in Column 6. If the cost per unit was derived from the plan's own experience and adjusted for co-payments, the explanation would be shown in Column 5 and the amount of the adjustment would be placed in the Column 7.

APPENDIX W
ACTUARIAL COST AND UTILIZATION ASSUMPTIONS
QUEST
(continued)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Service	Unit of Service	Annual Utilization Per 1,000 Eligibles	Cost Per Unit	Explanation of Assumptions [1]	Increase (Decrease) in Utilization	Increase (Decrease) in Cost per Unit	Cost Per Member Per Month
Physician Total							
Office/Home Visits	Visits						
Inpatient Visits	Visits						
NF/DC Visits	Visits						
Psych Visits	Visits						
Surgery							
Inpatient	Procedures						
Outpatient	Procedures						
Office	Procedures						
Other	Procedures						
Maternity							
Normal	Deliveries						
C-Section	Deliveries						
Misc	Deliveries						
Lab							
Inpatient							
Outpatient	Procedures						
Office	Procedures						
Other	Procedures						
	Procedures						

[1] List/describe the assumptions used to derive the utilization and costs estimates. For example, if utilization was derived from DHS claims data and decreased due to the implementation of managed care, such explanation would be placed in Column 5. The percentage increase or decrease in utilization would be placed in Column 6. If the cost per unit was derived from the plan's own experience and adjusted for co-payments, the explanation would be shown in Column 5 and the amount of the adjustment would be placed in the Column 7.

APPENDIX W
ACTUARIAL COST AND UTILIZATION ASSUMPTIONS
QUEST
(continued)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Service	Unit of Service	Annual Utilization Per 1,000 Eligibles	Cost Per Unit	Explanation of Assumptions [1]	Increase (Decrease) in Utilization	Increase (Decrease) in Cost per Unit	Cost Per Member Per Month
Radiology							
Inpatient	Procedures						
Outpatient	Procedures						
Office	Procedures						
Other	Procedures						
Consultations	Visits						
Eye Exams	Procedures						
Immunizations/Injections	Procedures						
Allergy	Procedures						
Emergency Services	Proceudres						
Other Medical	Procedures						
Preventive Care	Visits						
Administration							

[1] List/describe the assumptions used to derive the utilization and costs estimates. For example, if utilization was derived from DHS claims data and decreased due to the implementation of managed care, such explanation would be placed in Column 5. The percentage increase or decrease in utilization would be placed in Column 6. If the cost per unit was derived from the plan's own experience and adjusted for co-payments, the explanation would be shown in Column 5 and the amount of the adjustment would be placed in the Column 7.

APPENDIX W
ACTUARIAL COST AND UTILIZATION ASSUMPTIONS
QUEST
(continued)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Service	Unit of Service	Annual Utilization Per 1,000 Eligibles	Cost Per Unit	Explanation of Assumptions [1]	Increase (Decrease) in Utilization	Increase (Decrease) in Cost per Unit	Cost Per Member Per Month
Other Services							
Transportation	Trips						
Lodging and Meals	Days						
PT, OT, Speech Therapy	Visits						
DME	Items						
Prescription Drugs	Prescriptions						
Supplies	Items						
Other							

[1] List/describe the assumptions used to derive the utilization and costs estimates. For example, if utilization was derived from DHS claims data and decreased due to the implementation of managed care, such explanation would be placed in Column 5. The percentage increase or decrease in utilization would be placed in Column 6. If the cost per unit was derived from the plan's own experience and adjusted for co-payments, the explanation would be shown in Column 5 and the amount of the adjustment would be placed in the Column 7.

CAPITATION RATE EXPLANATIONS
ADJUSTMENTS TO CAPITATED RATE

List any adjustments (in addition to those provided at Appendix X) used to determine the capitation rate. For example, if an estimated 6% decrease in overall utilization is expected due to the implementation of managed care and this was not applied to each service category, this assumption should be listed with the corresponding rate adjustment. Another example includes increase in preventive care, etc.

QUEST

Adjustment	Costs (Savings) Per Recipient Per Month

ADMINISTRATIVE COSTS ASSUMPTIONS

List the major components of the administrative portion of the capitated rate for QUEST.

QUEST

Adjustment	Costs (Savings) Per Recipient Per Month

Should agree to the administrative cost on Appendix S.

Appendix X
QUEST MEDICAL PLAN
REPORT/REFERRAL TO MED-QUEST DIVISION INVESTIGATOR
RE: SUSPECTED CASES OF MEDICAID FRAUD AND/OR ABUSE

Per QUEST Plan RFPs, cases of suspected fraud and/or abuse must be promptly reported to Med-QUEST Division, Medical Standards Branch Medicaid Investigator. Please submit this report within 30 days of discovery.

TO:	Ronald Kim, Medicaid Investigator Med QUEST Division, Medical Standards Branch P.O. Box 700190 Kapolei, Hawaii 96709-0190	Phone: (808) 692-8114 FAX: (808) 692-8131

QUEST Health Plan: _____	**Report Prepared By:** _____ Name/Title	**Date Prepared:** _____
SOURCE OF COMPLAINT	Name: _____ Position/Title: _____ Phone: _____ FAX: _____	
HEALTH PLAN CONTACT *(If different from person preparing this report)*	Name: _____ Position/Title _____ Phone: _____ FAX: _____	
SUBJECT ***(Check Off)*** ☐ **PROVIDER** ☐ **ENROLLEE**	Name: _____ ID No: _____ Specialty: _____ Island: _____	
SYNOPSIS/NATURE OF COMPLAINT *Date of Discovery:* _____		
PRELIMINARY INVESTIGATION *(If applicable, include approximate dollars involved)* **$** _____		

Appendix X
QUEST MEDICAL PLAN
REPORT/REFERRAL TO MED-QUEST DIVISION INVESTIGATOR
RE: SUSPECTED CASES OF MEDICAID FRAUD AND/OR ABUSE

Per QUEST Plan RFPs, cases of suspected fraud and/or abuse must be promptly reported to Med-QUEST Division, Medical Standards Branch Medicaid Investigator. Please submit this report within 30 days of discovery.

ACTION(S) TAKEN BY QUEST PLAN/ DISPOSITION OF CASE *(If applicable, indicate if any legal and/or administrative action taken)*	